



Dr. Paul Tang
Chair, Meaningful Use Working Group and Health IT Policy Committee (HITPC)
Office of the National Coordinator for Health Information Technology
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave. SW
Washington, DC 20201

Public and Population Health in Stage 3 of Meaningful Use

Dear Dr. Tang:

On behalf of AMIA (the American Medical Informatics Association), I am pleased to submit these comments to help inform your important discussions. AMIA is the professional home for biomedical and health informatics and is dedicated to the development and application of informatics in support of patient care, public health, teaching, research, administration, and related policy. AMIA and its members are transforming health care through trusted science, education, and practice in biomedical and health informatics. AMIA members – 4,000 informatics professionals from more than 65 countries – work throughout the health system in various clinical care, research, academic, government, and commercial organizations.

AMIA is writing to implore the Health IT Policy Committee (HITPC) Meaningful Use Working Group and the HITPC to reconsider its initial decision to remove several population and public health-related objectives from their recommendations for stage 3 of the meaningful use (MU) program. AMIA's comments are in support of similar comments being submitted by the Joint Public Health Informatics Taskforce (JPHIT) and its public health member organizations.

Specifically, AMIA recommends the following:

1. Electronic Laboratory Reporting (ELR) and Syndromic Surveillance (SS) should remain "Core" measures for Eligible Hospitals (EHs) in MU stage 3.
2. Meaningful use must move even further to incentivize electronic health record (EHR) technology functionalities that help healthcare professionals comply with state public health laws that require them to notify health authorities of patients with reportable health conditions (case reporting).

3. It is possible to accomplish these first two recommendations while still reducing the total number of meaningful use objectives by combining some of the public and population health objectives and making the resulting objective a “Core” objective.

Rationale

More generally, AMIA seeks the rapid advancement of a robust information infrastructure that supports the interoperable exchange of data between clinical and population health systems in support of national health care goals including patient safety, quality, and affordability. Continuation of the current stage 2 requirements for ELR and SS will advance progress to date with respect to public health reporting and, at the very least, provide the opportunity for EHs to comply with current reporting requirements in a more efficient way once sufficient investments have been made in the infrastructure to support electronic reporting.

Surveillance is a core function of public health according to the Institute of Medicine. This function requires timely and complete reporting from health care providers. Over the last 15 years, numerous studies have demonstrated that electronic submission of information benefits public health agencies, providers, and patients.^{1,2,3} Agencies receive more timely and complete information, enabling them to effectively detect and respond to disease outbreaks.^{4,5} Providers may reduce case follow-up paperwork when data are electronically transmitted directly from an EHR system. Patients benefit by receiving more timely follow up from public health workers who can offer prophylaxis for family and co-workers for highly communicable diseases – such as meningococcal meningitis – while providing access to health care services for populations with chronic diseases such as HIV and Hepatitis C. Therefore, public health reporting, which includes ELR, SS, disease registries and case reporting, is critical for maintaining and improving the public's health and safety.

Inclusion of public health reporting measures in stages 1 and 2 of the HITECH meaningful use program has been helpful in many parts of the U.S. in providing a framework for state and local public health agencies to work with their provider counterparts to enhance their electronic

¹ Effler P, Ching-Lee M, Bogard A, Jeong MC, Nekomoto T, Jernigan D. Statewide system of electronic notifiable disease reporting from clinical laboratories: comparing automated reporting with conventional methods. *JAMA*. 1999;282(19):1845-50.

² Overhage JM, Grannis S, McDonald CJ. A comparison of the completeness and timeliness of automated electronic laboratory reporting and spontaneous reporting of notifiable conditions. *Am J Public Health*. 2008;98(2):344-50.

³ Buehler JW, Sonricker A, Paladini M, Soper P, Mostashari F. Syndromic Surveillance Practice in the United States: Findings from a Survey of State, Territorial, and Selected Local Health Departments. *Advances in Disease Surveillance*. 2008;6(3):1-20.

⁴ Griffin BA, Jain AK, Davies-Cole J, Glymph C, Lum G, Washington SC, et al. Early detection of influenza outbreaks using the DC Department of Health's syndromic surveillance system. *BMC Public Health*. 2009;9:483.

⁵ Loveridge P, Cooper D, Elliot AJ, Harris J, Gray J, Large S, et al. Vomiting calls to NHS Direct provide an early warning of norovirus outbreaks in hospitals. *The Journal of hospital infection*. 2010;74(4):385-93.

reporting and information exchange capabilities. These measures have encouraged the few states which do not facilitate electronic reporting to adopt ELR and syndromic surveillance. The measures have also provided the market pressure for EHR vendors to expand their systems' integration with information system vendors that serve public health agencies – vendor communities that have previously operated in isolation from one another. Inclusion in stage 2 further spurred innovation in the creation of new software companies and vertical service offerings from a range of vendors, including many statewide health information exchanges to support clinical and public health capacity for interoperable exchange in support of public health reporting. AMIA believes that the removal of these objectives from MU stage 3 would jeopardize the current efforts supporting public and population health and would limit further innovation in the area.

Broader Policy Context

More time and attention is needed to progress the public health reporting objectives set out in MU stages 1 and 2 to achieve their full potential in transforming the public's health. Furthermore, MU stage 3 objectives need to build on existing objectives to ensure that EHRs are fully integrated into the evolving national information infrastructure that supports population health activities and public health departments. Prior to the stages 1 and 2, few states provided the necessary infrastructure to connect EHR systems to public health information systems. Since 2010, rapid progress has been made in a number of states, such as Kansas, Kentucky, Maryland, Louisiana and Florida.

While progress has been slow in other states and available messaging and vocabulary standards are heterogeneous in their implementation, these should not serve as reasons to halt progress towards the nation's public health goals. Instead, AMIA recommends that ONC and HISPC look at stage 3 objectives as an opportunity to further advance the nation's public health infrastructure by supporting continued adoption and maturity of standards to enable interoperable exchange of data between clinical and public health organizations, disease registries and other entities focused on population health.

The meaningful use program has successfully advanced many areas of health IT adoption, including clinical decision support, standardized vocabularies, and electronic prescribing. While it may not be as apparent as the other areas, the inclusion of public health reporting measures has helped focus attention on the need for bidirectional exchange of information between clinical and population health organizations. AMIA recommends continued support for the implementation and meaningful exchange of EHR data on populations through the inclusion of public health reporting objectives as "Core" in MU stage 3. AMIA suggests that these public health reporting objectives or a single composite public health reporting objective be

structured from the existing “Menu” objectives for specialty registries, case reporting, and syndromic surveillance. The inclusion of public health reporting as a "Core" objective is needed to ensure the continued commercial support for initiatives that enable the use of health care data by public health agencies, the reduction of public health case reporting paperwork by providers, and the delivery of enhanced public health services to patients and populations that electronically transmitted data facilitates.

Concluding Remarks

We hope that the Meaningful Use Working group and the Health IT Policy committee will reconsider the inclusion of ELR, syndromic surveillance and case reporting in stage 3 of Meaningful Use *as part of a consolidated population health-focused “Core” objective.*

As a source of informed, unbiased opinions on policy issues relating to the national health information infrastructure, uses and protection of clinical and personal health information, and public health considerations, AMIA appreciates the opportunity to submit these comments. Please feel free to contact me or Dr. Ross Martin, AMIA’s Vice President of Policy and Development, at ross@amia.org at any time for further discussion of the issues raised here. AMIA stands ready to help ensure that these important functions are implemented and deployed to meet critical population health needs.

Sincerely,

A handwritten signature in black ink that reads "Blackford Middleton". The signature is fluid and cursive, with a long horizontal stroke at the end.

Blackford Middleton, MD, MPH, MSc, FACMI
Chair, AMIA